STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	09/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for the Investigation of Complaints IN00115087 and IN00115289. Complaints IN00115087 and IN00115289 - Substantiated. State residential deficiencies related to the allegations are cited at R090. Survey Dates: September 4, 5, 2012 Facility number: 000105 Provider number: 155198 AIM number: NA Survey team: Chuck Stevenson RN Connie Landman RN Census bed type: SNF: 80 Residential: 53 Total: 133 Census payor type: Medicare: 28 Other: 105 Total: 133 Sample: 3 These state residential findings are cited	R0000	The creation and submission of this plan of correction does not constitute as an admission of any conclusion set forth in the statement of deficiencies or any violation of regulation(s).	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	in accordance with 410 IAC 16.2. Quality review 9/07/12 by Suzanne Williams, RN			

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R0090	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any			

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	subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on record review and interview, the facility failed to report to the State Agency and fully investigate an allegation of verbal abuse of a staff member to a resident (Resident B) for 1 of 3 residents reviewed for staff abuse and reporting in a sample of 3, and of 13 residents residing on the facility's secured dementia unit. Findings include: 1. The record of Resident B was reviewed on 9/04/12. Diagnoses included, but were not limited to, dementia, coronary artery disease, hypertension, psychosis, and atrial fibrillation. An email from the Director of Assisted Living to the Human Resources Director dated 7/09/12 indicated "...I received a call from (LPN # 2) one of my nurses at home on July 4th 2012 at about 3PM. (LPN #2) called to report that (CNA #3) and (CNA #4) a couple of CNAs that work Reflections (the facility's secured	R0090	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Management staff thoroughly investigated the report that there may have been an allegation, and was unable to substantiate that such an allegation existed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by the alleged deficient practice. All Assisted Living clinical staff will be re-educated regarding the community's policy on reporting abuse. The administrator has thoroughly reviewed the policy, and will report future statements of concern that staff may have allegations that abuse may have occurred. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** All staff are educated upon hire and	10/05/2012

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	dementia unit) had told her they heard another CNA (CNA #1) be verbally abusive to the residents...(LPN #2) said she called (facility Administrator) the night before to let him know when they reported this to her...I called (facility Administrator) soon as (sic) I got off the phone with (LPN #2) to report this to him..." An email from the Human Resources Director dated 8/06/12 addressed to the Executive Director and Administrator indicated "Subject: Follow Up On Reflections Concerns (LPN #2)...Last week I met with (LPN #2) and (Director of Assisted Living) to discuss her written concerns about (CNA #1)...being verbally inappropriate to a resident...(LPN #2) alleges that (CNA #1) was overheard by (CNAs #3 and #4) being verbally inappropriate toward a male resident (Resident B). He allegedly hit (CNA #1) as a result of the aggravation... This week I will meet with (CNAs #4 and #3, and #1 and Reflections Unit Manager) regarding the allegations and to discover how these alleged incidents were investigated, documented and resolved..." The Reflections Unit Manager was interviewed on 9/05/12 at 3:15 p.m. She indicated she was aware of all the issues surrounding the allegations of verbal		re-educated on an annual basis that residents should be protected from abuse and staff are responsible to immediately report abuse to management. Going forward, the administrator or his designee will report future statements of concern that staff may have allegations that abuse may have occurred. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Assisted Living managers will complete 5 random staff interviews weekly through October 26, 2012, and 3 random staff interviews weekly through November 16, 2012. Information gathered from the audits will be forwarded to the QA committee to determine if further interviewing and education is necessary. See Attachment A, Abuse Reporting Audit Form.	

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	abuse by CNA #1, and was aware the allegation had not been reported to the State Agency. The Executive Director was interviewed on 9/05/12 at 1:30 p.m. He indicated he was aware of the allegations of verbal abuse by CNA #1, and was aware the incident had not been reported to the State Agency. 2. A facility document titled "Abuse Prevention" dated 6/15/09, received from the Executive Director on 9/04/12 at 4:00 p.m., indicated: "Policy Abuse Prevention Statement: It is the mission of this facility to establish a resident sensitive and secure environment to assure proper and respectful treatment of all residents. The facility is obligated to insure that residents have the right to be free from verbal, mental, physical and sexual abuse...The facility will not tolerate any abuse and will promptly and thoroughly investigate any allegation of abuse, neglect... Policy Implementation: Investigation of Incidents and Allegations...The DON (Director of Nursing) shall be responsible for the investigation of the alleged incident...The investigator(s) will use the Internal Investigation Report (IIR)			

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	form...If the IIR form indicates potential alleged abuse, the Administrator/Director of Nursing will notify the Indiana State Department of Health within 24 hours of the alleged incident..." This state residential tag relates to complaint IN00115087 and IN00115289.			